

**AGREEMENT FOR TEMPORARY PAY ADJUSTMENT  
COVERING PHYSICIAN CLINICAL NIGHT/WEEKEND ON-CALL  
COVERAGE**

I \_\_\_\_\_ (*please print full name*) agree to provide temporary night/weekend on-call physician-level clinical care coverage as prescribed per attached description of duties starting July 1, 2003. I understand that the need for these temporary night/weekend on-call duties will end on June 30, 2004. I understand that this temporary night/weekend on-call duty requires that I will be available in the Clinical Center, NIH, during my scheduled nights, as per prescribed schedule, and that I will have use of an "on-call" room located in Building 10. My responsibilities will be to \_\_\_\_\_

I understand that compensation for the physician night/weekend on-call services in the Clinical Center during the one-year period noted above will be paid as a supplement. Currently, my base pay is \$ \_\_\_\_\_. (*including locality pay*). I understand that the supplement for the temporary night/weekend on-call services will be paid to me in the amount of \$ \_\_\_\_\_. This temporary supplement will be paid to me in 26 equal payments (*less appropriate taxes and deductions*) over this twelve-month period. Because of the payroll system, there is no way to reflect the temporary supplement as a separate payment from base pay. Therefore, any COLA or other pay adjustments during this one-year period, as well as eligibility and employee payments for certain benefits (e.g., life insurance) will be calculated on the combined total of the base pay (\$ \_\_\_\_\_) and the temporary on-call supplement amount of \$ \_\_\_\_\_. I understand that any pay adjustments or benefits which are calculated on the combined total are NOT part of my regular base pay.

I understand and agree that when my obligation under this agreement ends, the temporary supplement of \$ \_\_\_\_\_ will be discontinued and I will continue to receive my regular base pay for my position. I further understand that certain benefits calculated against the previous total will also be reduced (e.g., life insurance). I understand that the removal of this temporary supplement for on-call duties, when the need for my services ends, will in no way be construed as a penalty or adverse action. I also understand that should I be unable to fulfill my one-year commitment, the temporary supplement for these on-call services will end at the same time.

In signing this form, I agree to perform these responsibilities during the one-year period.  
Signatures:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date  
Scientific Director or Clinical Director